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# A Guide to Healthcare Terms & Definitions

## THE WORLD OF HEALTH INSURANCE CAN BE CONFUSING, SO THIS GUIDE WAS CREATED TO:

- Define some of the common terms related to health insurance and prescription coverage
- Make it easier for you to understand some of the concepts that impact your coverage and spending

This document is intended to help patients and caregivers understand some common features of many health insurance plans. It does not replace any terms or conditions in specific plans. Patients and caregivers should consult their health insurance plans for questions specific to them.

# Types of Health Insurance

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## THERE ARE TWO MAIN KINDS OF HEALTH INSURANCE:

### Commercial Health Insurance:

Any type of health insurance policy not offered or provided by the government is called commercial health insurance. People often enroll in commercial health insurance through an employer. The employer either covers the premium or part of it and the remaining cost is taken out of the employee's paycheck.

#### Employer-Sponsored Health Insurance

Also known as a "group health plan," this is a health plan offered by an employer that provides health coverage to employees and their families. It is a type of commercial insurance.

### Government-Funded Health Insurance:

In the US, the six major government programs are:

- Medicare
- Medicaid
- State Children's Health Insurance Program (SCHIP)
- Department of Defense TRICARE and TRICARE for Life programs (DOD TRICARE)
- Veterans Health Administration (VHA) program
- Indian Health Service (IHS) program

Some of these programs offer "subsidized coverage" for people with incomes below certain levels. Health coverage is available at low or no cost because it is funded by the government.

# General Healthcare Terms

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### Allowed Amount/Maximum Allowable

This is the maximum amount a health insurance plan will pay for a covered healthcare service. If your healthcare provider charges more than the plan's allowed amount, you may have to pay the difference.

### Appeal

If your health insurance plan denied you a benefit or payment, an appeal is a request you can make asking them to review that decision.

### Assignment of Benefits (AOB)

When you sign paperwork authorizing your health insurance plan to pay a specialty pharmacy directly, it's called assignment of benefits (AOB). Under an AOB arrangement, a specialty pharmacy will generally ship a specific dose of your medication to your healthcare provider for your individual use. The specialty pharmacy may verify your insurance information and subsequently bill you for copayment.

## GOVERNMENT-FUNDED HEALTH INSURANCE TERMS

### Medicaid

Medicaid is a health insurance program that is funded by the state and provides free or low-cost health coverage to some low-income people and people with disabilities.

### Medicare

Medicare is a federal health insurance program for people 65 and older and certain young people with disabilities. If you're eligible, you can choose one or more of these options:

### Medigap

A Medigap plan, also called a Medicare Supplement, is health insurance that is sold by private companies. It can help pay some of the costs Medicare doesn't cover like copays, coinsurance, and deductibles.

### Dual-Eligible Beneficiaries

People who are enrolled in both Medicare and Medicaid are known as dual-eligible beneficiaries.

| Medicare Part A | Medicare Part B | Medicare Part C *(also called Medicare Advantage)* | Medicare Part D |
|---|---|---|---|
| Covers things like hospital care, skilled nursing facility care, hospice, and home health services. | Covers medically necessary services and preventive services, including physician-administered drugs. | Offered by Medicare-approved private companies. In Medicare Advantage, you still have Part A and Part B coverage, but you may also have coverage for things Original Medicare doesn't cover, such as fitness programs and some vision, hearing, and dental services. | Covers prescription drugs. |

# General Healthcare Terms

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### Benefits
Benefits are the healthcare items or services that are covered under your health insurance plan.

### Claim
A claim is a request for payment that you or your healthcare provider submits to your health insurance plan for the services you received.

### Coordination of Benefits
When you have more than one health insurance plan, coordination of benefits is used to uncover which health insurance plan is responsible for paying first when you have a medical claim.

### Copayment (or copay)
A copay is a fixed amount (for example, $25) that you pay for a covered health insurance service. See "A Copay Roadmap" below for more details.

## A COPAY ROADMAP

Words related to your insurance copayments, or copays, are important to understand because they determine your out-of-pocket costs.

### Deductible
This is the amount you pay out of your pocket for covered healthcare services before your insurance plan starts to pay.

### Coinsurance
Coinsurance is the percentage of the cost of a covered healthcare service that you're responsible for after you've paid your deductible. For instance, if an office visit costs $100 and you haven't paid your deductible, you will pay the full $100. If you have paid your deductible and your coinsurance is 20%, you will pay $20.

### Cost Sharing
This is the share of costs covered by your insurance that you pay out of your pocket. Cost sharing usually includes deductibles, coinsurance, and copays.

### In-Network Copay/Coinsurance
When you visit healthcare providers who contract with your health insurance plan, your copays/coinsurance usually are less than out-of-network copayments.

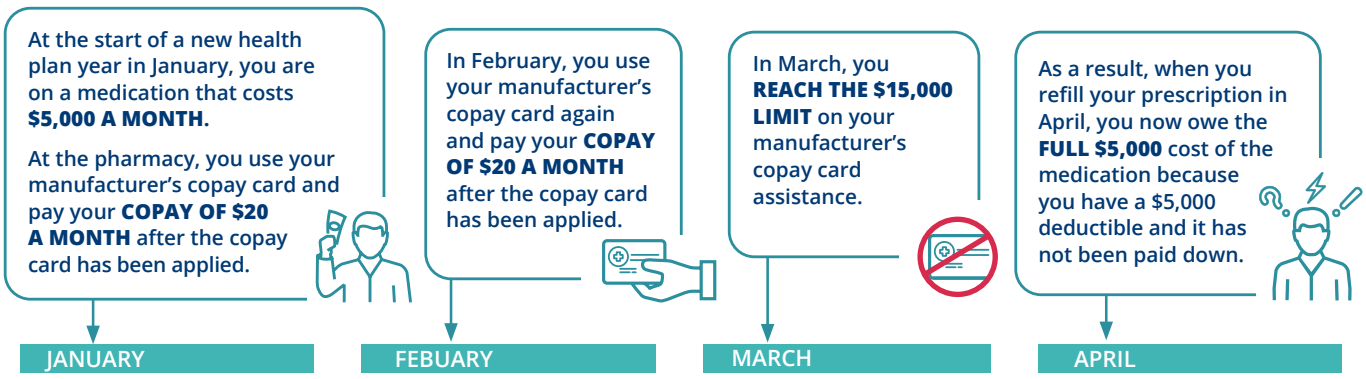
### Out-of-Network Copay/Coinsurance
When you visit healthcare providers who don't contract with your health insurance plan, your copays/coinsurance are typically higher than in-network copays/coinsurance.

## COPAY ACCUMULATORS AND COPAY MAXIMIZERS

Some drug manufacturers offer copay cards/coupons, or copay assistance, to help certain patients cover the cost of their medication. These copay assistance programs are meant to help patients with their costs. However, some health insurance plans have put policies in place that shift more cost onto patients, while enabling the health insurance plan to benefit from the savings instead. These policies include **copay accumulators** and **copay maximizers**.

### Copay accumulators

A copay accumulator is a feature in some health insurance plans where a drug manufacturer's payments do not count toward the patient's deductible and out-of-pocket maximum. Here is an example where a patient has a $5,000 deductible and a copay card with a $15,000 limit, and the patient's health insurance plan uses a copay accumulator:




> Since your health insurance plan uses a **COPAY ACCUMULATOR**, the manufacturer's copay card assistance ***DID NOT*** count toward your deductible.

### Copay maximizers

Under a copay maximizer model, the health insurance plan intentionally changes the copays for various medications to ensure that the health insurance plan receives the full value of the drug manufacturer's copay savings program.

**Example:** Rather than using a standard $25 copay for a branded drug, a health insurance plan might set the copay at $1000 per month when the drug manufacturer has made a copay coupon available with a maximum annual benefit of $12,000.

> **If you've been prescribed an Ipsen medicine and have questions about your health insurance, an IPSEN CARES Patient Access Specialist can verify your health benefits and review your coverage with you.**

# General Healthcare Terms

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### Exclusion

An exclusion is a condition, service, or drug that is not covered by your health insurance plan.

### Explanation of Benefits (EOB)

An EOB is a statement from your health insurance plan describing what costs it will cover for medical care or products you've received. The EOB is generated when your healthcare provider submits a claim for the services you received.

### Formulary

Also called a "drug list," this is the list of prescription drugs covered by your prescription drug plan or your health insurance plan's prescription drug benefits. Many formularies are "tiered." See example below.

### High-Deductible Health Plan (HDHP)

This is a type of health insurance plan with a higher deductible than most. The monthly premium is usually lower, but you pay more healthcare costs yourself before the insurance company starts to pay its share.

## TIERED FORMULARY

A tiered formulary divides drugs into groups based mostly on cost. A health insurance plan's formulary might have 3, 4, or even 5 tiers. Typically, the lowest-tier drugs are the lowest cost.

The table below is an example of a 4-tier formulary:

| Drug Tier | Type of Drugs Included | Your Cost |
|---|---|---|
| **Tier 1** | Most generic drugs | Lowest copay |
| **Tier 2** | Most common brand name drugs<br>Preferred brand name drugs<br>Some high-cost generic drugs | Medium copay |
| **Tier 3** | Non-preferred brand name drugs | Highest copay |
| **Tier 4**<br>*(Specialty Tier)* | Unique or very high-cost drugs | Percentage of total drug cost, called "coinsurance" |

# General Healthcare Terms

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### Individual Plans

Also called "individual health insurance policies," these are policies for people who don't have coverage through their employer. These health insurance plans are regulated under state law.

### Medically Necessary

If certain healthcare services or supplies are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms, they are considered medically necessary.

### Open Enrollment Period

This is the yearly period in the fall when you can enroll in a health insurance plan for the next calendar year.

### Out-of-Pocket Limit/Maximum Amount

Your out-of-pocket limit is the most amount of money you will have to pay for covered services in a year. After you have spent your out-of-pocket limit on deductibles, copays, and coinsurance, your health insurance plan pays 100% of the cost of covered benefits.

## UNDERSTANDING MANAGED CARE AND NETWORKS

Managed care is a type of healthcare that attempts to manage the cost of medical services while keeping quality high. The primary way managed care plans do this is by setting up provider networks. Some require you to use the provider network to receive care. Examples of managed care plans include HMOs, EPOs, and PPOs.

Here are some types of managed care health insurance plans:

| Exclusive Provider Organization (EPO) | Health Maintenance Organization (HMO) | Preferred Provider Organization (PPO) |
|---|---|---|
| In an EPO, services are covered only if you go to doctors, specialists, or hospitals in the plan's network, except in an emergency. | HMOs usually limit coverage to care from healthcare providers who work for or contract with the HMO. An HMO typically won't cover out-of-network care except in an emergency. | A PPO contracts with medical providers, such as hospitals and doctors, to create a network of participating healthcare providers. You pay less if you use providers who belong to the plan's network. |

# General Healthcare Terms

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### Lifetime Maximum

Before the Affordable Care Act law was passed, health insurance plans could set a lifetime maximum — a dollar limit on what they would spend for your covered benefits during the entire time you were enrolled in that plan. You were required to pay the cost of all care exceeding those limits. Now plans can no longer set a dollar limit on what they spend on health benefits for your care.

### Pharmacy Benefits Managers (PBMs)

PBMs are companies that manage prescription drug benefits for health insurance plans, Medicare Part D drug plans, and large employers. They negotiate drug prices with drug manufacturers and often decide which drugs will be covered.

### Premium

Your premium is the amount you pay for your health insurance every month. In addition to your monthly premium, you usually pay other healthcare costs, like deductibles, copays, and coinsurance.

## INSURANCE BILLING & CODING TERMS

Medical billing and coding is the process of identifying a diagnosis, medical test, treatment, or procedure and putting it into a standardized code so it can be submitted to the health insurance plan and healthcare providers can get reimbursed.

### CPT Codes

CPT stands for current procedural terminology. These codes are numbers used to describe tests, surgeries, evaluations, and other medical procedures performed by healthcare providers.

### HCPCS

HCPCS stands for Healthcare Common Procedure Coding System, the system used by doctors to bill your health insurance plan for medical procedures.

### J Codes

These are billing codes used for the medical devices, supplies, and drugs when billing for health insurance claims.

### ICD-10-CM Codes

ICD-10-CM stands for the International Classification of Diseases, 10th revision, Clinical Modification. These codes classify patients' diseases, symptoms, and injuries.

### NDC

NDC stands for National Drug Code. It's a unique 10- or 11-digit, 3-segment number, and it can be used to identify any drug in the United States. The first set of numbers refers to the drug manufacturer. The second set identifies the strength and dose form (eg, capsule, tablet, liquid). The third identifies the type of package.

# General Healthcare Terms

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### Prior Authorization/Preauthorization

Some drugs, tests, and other services may need approval from your health insurance plan before you receive them. Using the prior authorization process, your plan will decide if that drug, test, or service is medically necessary for you before covering the cost.

### Reimbursement

This is the payment that healthcare providers receive for providing you a medical service.

### Specialty Pharmacy

A specialty pharmacy is a type of pharmacy that offers medications to help treat rare and complex medical conditions, which often need special handling, storage, and administration.

### Supplemental Insurance

Also called "secondary insurance," this is extra insurance you can buy to help pay for services and out-of-pocket costs that your regular health insurance plan doesn't cover, like copays, deductibles, and coinsurance, or dental or vision costs.

## HEALTHCARE LAWS

Government agencies create regulations (also known as "rules") under the authority of Congress to help the government carry out public policy. Here are some of the healthcare laws that affect health insurance:

**Consolidated Omnibus Budget Reconciliation Act (COBRA)**

**1985**

COBRA gives workers and their families who lose their health insurance benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time. It is available under certain circumstances, such as job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events.

**Health Insurance Portability and Accountability Act (HIPAA)**

**1996**

This is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.

**Affordable Care Act (ACA)**

**2010**

The Patient Protection and Affordable Care Act, referred to as the Affordable Care Act or ACA, is a comprehensive healthcare reform law. It was enacted in March 2010 with the goal of making affordable health insurance available to more people.

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**Call (866) 435-5677**

Our Patient Access Specialists are available Monday-Friday, from 8:00 AM to 8:00 PM ET (5:00 AM to 5:00 PM PT).

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